DeSales University

MEDICAL HISTORY AND PHYSICAL EXAMINATION

This report will aid the Health Center Staff in providing the best possible health care while you are attending DeSales University. The information is strictly confidential.

TO THE STUDENT: *Please print or type.* Complete this side of the form. Your physician must complete the medical examination report and immunization record on the reverse side.

Last Name | First Name | Middle Name | Social Security No. | Sex | Expected Graduation Year

Home address (Street and Number) | City | State | Zip Code | Cell Phone | Date of Birth

Father's Name (or spouse if adult student) | Occupation | Business Phone | Home Phone

Mother's Name (or spouse if adult student) | Occupation | Business Phone | Home Phone

Person to contact in case of emergency (other than mother/father/spouse as above) | Emergency Phone Number

MEDICAL HISTORY

Do you have or ever had:

	Yes	No		Yes	No
Any hospitalizations?	❑	❑	Significant head injury?	❑	❑
Any operations?	❑	❑	Infectious mononucleosis?	❑	❑
Chickenpox or varicella vaccine?	❑	❑	Depression or anxiety disorder?	❑	❑
Asthma or chronic respiratory disease?	❑	❑	Eating disorder?	❑	❑
Heart disease or murmur?	❑	❑	Other serious or chronic illness or injury?	❑	❑

Please give details (including dates) of any questions you answered "yes" to:

Please list any family history of serious illness or premature death due to illness:

Please list all medications you are allergic to:

Please list all allergies to foods or environmental agents:

Please list all medications you take regularly:

INSURANCE DATA: ***Attach a photocopy of medical insurance and prescription cards (both sides).***

Name of Insurance Company: Group and Certificate No.:

Student's Signature: Date:

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Return to: DeSales University Health Center
McShea Student Center
2755 Station Avenue
Center Valley, PA 18034